

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03763

3779

## CERTIFICATE OF DEATH

Rec'd. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Talbot</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		b. COUNTY <u>Talbot</u>	
c. LENGTH OF STAY IN lb <u>18 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>40 Easton</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION —		d. STREET ADDRESS <u>Bay &amp; Washington St</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Edna</u>		First <u>H.</u>	Middle <u>Bergere</u>
4. DATE OF DEATH Month <u>Mar.</u> Day <u>7</u> Year <u>1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <u>Dec. 1, 1888</u>		9. AGE (In years lost birthday) <u>69 yrs.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Montgomery Todd</u>		14. MOTHER'S MAIDEN NAME <u>Ida Amelia Eronick</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u>		16. SOCIAL SECURITY NO. <u>109-01-7449</u>	
17. INFORMANT <u>Louis Bergere</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>17ox</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), sloing the under- lying cause lost. (b) DUE TO (c)	
		INTERVAL BETWEEN ONSET AND DEATH <u>4 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>26ox</u> <u>Diabetes mellitus</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July</u> , 19 <u>53</u> , to <u>7 Mar</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>9 Aug</u> , 19 <u>58</u> , and that death occurred at <u>8:50 PM</u> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <u>Easton, Maryland</u>	
ACTUAL SIGNATURE <u>Thurston Harrison</u>		DATE SIGNED <u>Aug 1958</u>	
PHYSICIAN'S NAME (Type) <u>THURSTON HARRISON</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Mar. 10, 1958</u>	
22c. NAME OF CEMETERY OR CREMATORIUM <u>Spring Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Easton, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John D. Williams</u>		ADDRESS <u>Easton, Md.</u>	
		24e. REC'D. BY REGISTRAR <u>MART 1 1958</u>	
		24f. REGISTRAR'S SIGNATURE <u>John D. Williams</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 10/57

THE STATE OF PENNSYLVANIA  
DEPARTMENT OF HEALTH—BALTIMORE

CERTIFICATE OF DEATH

BUREAU Y.  
MAR 11 1958  
RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3798

## CERTIFICATE OF DEATH

03764

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Talbot		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Washington, D.C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) St. Michaels		c. LENGTH OF STAY IN 1b 10 Months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C. 47 X - 3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rio Vista Vursing Home				d. STREET ADDRESS 5 W St. N.W.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First Jane	Middle Caroline	Last Blumer	4. DATE OF DEATH March 20 1958
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH May 11, 1878	9. AGE (In years last birthday) 79 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Drug Store		11. BIRTHPLACE (State or foreign country) New York	
12. CITIZEN OF WHAT COUNTRY? US					
13. FATHER'S NAME Henry F. Blumer		14. MOTHER'S MAIDEN NAME Marie Friesez			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No		17. INFORMANT H.E. Midgett 52 W St. NW. Wash. D.C.	
Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 2 days			
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 493X pneumonia, Terminal, Hypertension		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6-10, 1952, to 3-20, 1958, that I last saw the deceased alive on 3-20, 1958, and that death occurred at 11:57 A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE Physician's Name (Type) Mary M. Reeser, Jr.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/22/58		22c. NAME OF CEMETERY OR CREMATORIAL Olivet Cemetery	
22d. LOCATION (City, town, or county) St. Michaels		(State) Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Normand Marshall		ADDRESS St. Michaels, Md.		24a. REC'D BY REGISTRAR DATE MAR 26 '58	
				24b. REGISTRAR'S SIGNATURE Deborah	

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF CASH

STATE OF CALIFORNIA - DIVISION OF MUNICIPAL CORPORATIONS

BUREAU V. S.

JAN 29 1933

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 20 Film 227 4-9-58 ams  
3780

**FOR STATE  
HEALTH DEPT.**

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS  
2/57

		303765			
		Reg. Dist. No.			
1. PLACE OF DEATH a. COUNTY <u>TALBOT</u>		2. USUAL RESIDENCE (Where deceased lived. If institutional, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>		c. LENGTH OF STAY IN lb <u>40 hrs, 30 min</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>EASTON Memorial Hospital</u>		e. STREET ADDRESS <u>None</u>			
3. NAME OF DECEASED (Type or print) <u>Charles Thomas Clark</u>		4. DATE OF DEATH <u>Month 3 Day 30 Year 1958</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
5. SEX <u>Male</u> 6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 13, 1953</u>		
9. AGE (in years last birthday) <u>4 yrs.</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Charles Clark JR.</u>		14. MOTHER'S MAIDEN NAME <u>Ida ELBURN</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> 16. SOCIAL SECURITY NO. <u>Address</u>	
17. MEDICAL CERTIFICATION		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) <u>914.0</u> DUE TO <u>Electro Cut &amp; He caught hold of down electric wire &amp; was burned</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		(b) <u>Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause lost.</u> DUE TO <u>This occurred 3/28/58 &amp; he died 3/30/58</u>		(c)	
		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			
		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Caught hold of down electric wire</u>			
		20c. TIME OF INJURY Hour <u>a. m.</u> <u>p. m.</u>	Month, Day, Year <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>
		20f. (City or town) <u>Stevensville</u>	(County) <u>Md.</u>	(State) <u></u>	
		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>W. Henry Foster</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>3/30/58</u>	
EXAMINER'S NAME (Type) <u></u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/1/58</u>	22c. NAME OF CEMETERY OR CREMATORIY <u>Stevensville</u>	22d. LOCATION (City, town, or county) <u>Luzerne Co. Md.</u>	(State) <u></u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar L. Law Church Hill Md.</u>		ADDRESS <u></u>	24a. REC'D BY REGISTRAR <u>APR 2 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Albert</u>	

BUREAU V. A.

APR 2 1958

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03766

3781

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Talbot</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>Talbot</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>EASTON</b>	c. LENGTH OF STAY IN 1b <b>5 days</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>40 Easton, Md.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>EASTON Memorial Hosp.</b>		d. STREET ADDRESS <b>Goldsborough St. Ext</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Jacob</b>	First <b>Jacob</b>	Middle <b>W.</b>	Last <b>Cohen</b>
4. DATE OF DEATH <b>3</b>	Month <b>3</b>	Day <b>19</b>	Year <b>1958</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 15, 1886</b>
9. AGE (In years lost/birthday) yrs. <b>71</b>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Scrap Iron Dealer</b>	11. KIND OF BUSINESS OR INDUSTRY <b>10b. Scrap Iron Dealer</b>	12. BIRTHPLACE (State or foreign country) <b>Russia</b>
13. FATHER'S NAME <b>Yale Cohen</b>	14. MOTHER'S MAIDEN NAME <b>Fannie Spivak</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	16. SOCIAL SECURITY NO. <b>220-320044</b>	17. INFORMANT <b>Lewis Cohen, son - [REDACTED] - Son</b>	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) <b>420.1</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>	
Conditions, if any, which gave rise to immediate cause (o), stating the under- lying cause lost. (b) DUE TO			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m.	Month, Day, Year <b>19</b>	20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>3-15-58</b> , 19, to <b>3-14-</b> , 19, that I last saw the deceased alive on <b>3-14-</b> , 19, and that death occurred at <b>9:25</b> A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>921 Hanover St.</b>			
ACTUAL SIGNATURE <b>DONALD F. BARTLEY</b>	DATE SIGNED <b>3-19-58</b>		
PHYSICIAN'S NAME (Type) <b>DONALD F. BARTLEY MD.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Mar. 21, 1958</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Mountrose Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Talbot Chase (old) Cemetery</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Maurice E. Stevens, Son Easton Md.</b>		24a. REC'D BY REGISTRAR <b>MAR 24 '58</b>	24b. REGISTRAR'S SIGNATURE <b>W. L. French</b>
ADDRESS <b>Maurice E. Stevens, Son Easton Md.</b>		DATE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## CERTIFICATE OF DEATH

Form No. 104

RECEIVED

MAR 24 1958

RECEIVED

BUREAU V. S.

1  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03767

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 5 may be retained by your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		3782		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
Talbot		MARYLAND		a. STATE Maryland b. COUNTY Talbot	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Easton		3 months		Easton 40	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS	
416 North St.				416 North St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH Month Day Year
EDWARD ORMAN DYOTT, JR.					March 7, 1958
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (in years last birthday) 55 yrs.
Male		White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	March 7, 1903	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
canning house employee				Maryland	
12. CITIZEN OF WHAT COUNTRY?				U.S.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
Edward Orman Dyott		Naomi M. Page			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT	
		218-12-1191		Mrs. Frances Dyott	
				Address Easton, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Coronary occlusion			
420.1		DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)			
		DUE TO			
		(c)			
		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
19					
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>Louis Welty</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Dr. Louis S. Welty		DATE SIGNED 3-10-58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 11, 1958		22c. NAME OF CEMETERY OR CREMATORIUM Woodlawn Memorial Park	
				22d. LOCATION (City, town, or county) rural Easton, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Maurice E. Newnam & Son		ADDRESS Easton, Md.		24a. REC'D BY REGISTRAR DATE MAR 13 '58	
				24b. REGISTRAR'S SIGNATURE <i>Alfred</i>	

RECEIVED  
FEDERAL BUREAU OF INVESTIGATION  
U. S. DEPARTMENT OF JUSTICE  
MEDICAL EXAMINER - CERTIFICATE OF DEATH

STATE OF  
TEXAS

BUREAU V. S

MAR 13 1933

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3799

## CERTIFICATE OF DEATH

Reg. Dist. No.

03768

1. PLACE OF DEATH a. COUNTY <b>TALBOT</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WITMAN</b>		c. LENGTH OF STAY IN 1b <b>LIFE</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>ANNA</b>		First <b>BESSIE</b>	Middle <b>HADAWAY</b>
4. DATE OF DEATH <b>MAR 27 1958</b>		Month <b>MAR</b>	Day <b>27</b>
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>AUG. 8 1894</b>		9. AGE (In years lost birthday) <b>63 yrs.</b>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>NEAVSTT MD</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>OWEN W. HIGGINS</b>		14. MOTHER'S MAIDEN NAME <b>HENRIETTA JONES</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) -		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs. Louise Breeding, Witterman 2nd</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <b>Myocardial infarction</b> <b>arteriosclerotic coronary heart d</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 hr.</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>1-24-1958</b> to <b>3-27-1958</b> , that I last saw the deceased alive on <b>3-27-1958</b> , and that death occurred at <b>7:45 PM</b> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>St. Michaels Md</b>	
ACTUAL SIGNATURE <b>Theresa J. Guy M. Reeder Jr.</b>		DATE SIGNED <b>3-28-58</b>	
PHYSICIAN'S NAME (Type) <b>St. Michaels</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Mar. 31, 1958</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>Clint Cemetery</b>
22d. LOCATION (City, town, or county) <b>St. Michaels, Md</b>		(State)	
23. FUNERAL-DIRECTOR'S SIGNATURE <b>Hamilton Harrison, St. Michaels, Md</b>		24a. REC'D BY REGISTRAR DATE <b>APR 1 '58</b>	24b. REGISTRAR'S SIGNATURE <b>Alvarez</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

APR

BUREAU V.

APR 2 1958

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3783

## CERTIFICATE OF DEATH

03769

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Md.</u>		b. COUNTY <u>TALBOT</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>		c. LENGTH OF STAY IN lb <u>6 days.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>St. Michaels, Md.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Easton Memorial Hosp.</u>		d. STREET ADDRESS <u>7 N. Main</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <u>Hazel</u>	Middle <u>C.</u>	Last <u>Haddaway</u>	4. DATE OF DEATH	Month <u>3</u>	Day <u>10</u>	Year <u>1958</u>
5. SEX <u>F</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 7 1915</u>	9. AGE (In years last birthday) <u>43 yrs.</u>	IF UNDER 1 YEAR Months <u>—</u>	IF UNDER 24 HRS. Days <u>—</u>	Hours <u>—</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edward J. Willey</u>		14. MOTHER'S MADDEN NAME <u>Eva. M. Ensor</u>		Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. <u>218-20-9656</u>		17. INFORMANT <u>W. James Haddaway, st. michaels, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>451X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <u>Hero - prothrombin</u> (c) DUE TO <u>Medio. necrosis of the aorta</u>				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u>—</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>M.D.</u>		20f. (City or town) <u>219 S Washington St</u> (County) <u>Baltimore</u> (State) <u>Md.</u>	
21. I certify that I attended the deceased from <u>19</u> to <u>19</u> , that I last saw the deceased alive on <u>19</u> , and that death occurred at <u>10 15 AM</u> , from the causes and on the date stated above. ACTUAL SIGNATURE <u>E. C. H. Schmidt</u> ADDRESS (Street, city or town, state) <u>219 S Washington St</u> (Date signed) <u>10 March 58</u> PHYSICIAN'S NAME (Type) <u>E. C. H. Schmidt</u> Easton 16 Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/13/58</u>		22c. NAME OF CEMETERY OR CREMATORIUM <u>Olivet Cemetery</u>		22d. LOCATION (City, town, or county) <u>St. Michaels</u> (State) <u>Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>V. Hamilton Harrison, St. Michaels, Md.</u>		ADDRESS		24a. REC'D. BY REGISTRAR <u>REC'D. 4/14/58</u>		24b. REGISTRAR'S SIGNATURE <u>Av. Leach</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MAR 14 1968

REFUGEE

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3800

## CERTIFICATE OF DEATH

03770

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Talbot MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Talbot	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Royal Oak - Rural		c. LENGTH OF STAY IN 1b 20 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Gordon Middle L. Last Harris		4. DATE OF DEATH Month March Day 11 Year 1958	
5. SEX Male White		6. COLOR OR RACE 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	
8. DATE OF BIRTH apr. 30 1893		9. AGE (In years lost birthday) 64 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Staten Island, N.Y.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Wallace Rees Harris		14. MOTHER'S MAIDEN NAME Florence Lewis	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? Yes W.W.I		16. SOCIAL SECURITY NO. none 17. INFORMANT Jean Wallace Harris, Royal Oak Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 451X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		HOPTURED ABD. ANEURYSM INTERVAL BETWEEN ONSET AND DEATH Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept. 1957, to March 11, 1958, that I last saw the deceased alive on May 11, 1958, and that death occurred at 12:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Donald F. Bartley M.D.		ADDRESS (Street, city or town, state) 9 N. HANSON ST. DATE SIGNED 3-11-58	
PHYSICIAN'S NAME (Type) DONALD F. BARTLEY M.D.		EASTON MD.	
22a. BURIAL/CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/14/58	
22c. NAME OF CEMETERY OR CREMATORIAL Fawncliff Cemetery		22d. LOCATION (City, town, or county) Hartsdale (State) N.Y.	
23. FUNERAL DIRECTOR'S SIGNATURE John D. Williams		ADDRESS Easton, Maryland	
24a. REC'D BY REGISTRAR MAR 13 '58		24b. REGISTRAR'S SIGNATURE W. L. Smith	
VS A15 (4) 15M 9/55		DATE	

MARYLAND STATE DEPARTMENT OF JUSTICE - BUREAU

CERTIFICATE OF DEATH

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BUREAU Y. S.

MAR 18 1953

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3784

## CERTIFICATE OF DEATH

Reg. Dist. No.

03771

1. PLACE OF DEATH a. COUNTY <i>Talbot</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Talbot</i>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>		c. LENGTH OF STAY IN 1b <i>27 days.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Neavitt</i>							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Memorial Hospital</i>		d. STREET ADDRESS <i>None</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First <i>Samuel</i>	Middle <i>H</i>	Last <i>Harrison</i>	4. DATE OF DEATH <i>March 22 1958</i>	Month	Day	Year				
5. SEX <i>Male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug. 8, 1878</i>	9. AGE (In years last birthday) <i>79 yrs.</i>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Mail Carrier</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Mail Carrier</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>					
13. FATHER'S NAME <i>John Harrison</i>		14. MOTHER'S MAIDEN NAME <i>Susan McGuay</i>		Address							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or date of service) <i>Not known</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>not quite Mrs. Susan Harrison (wife)</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>498X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) <i>Cystostomy - thrombosis, right leg</i>		INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter name of injury in Part I or Part II of item 18.) <i>Post op</i>		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>M.D.</i>	20f. (City or town) <i>719 S. Washington St.</i>	(County) <i>Baltimore</i>	(State) <i>Md.</i>
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, and that death occurred at 3:15 AM, from the causes and on the date stated above.								ADDRESS (Street, city or town state) <i>E. C. H. Schmidt</i>	DATE SIGNED <i>Mar 28 1958</i>		
ACTUAL SIGNATURE <i>E. C. H. Schmidt</i>		PHYSICIAN'S NAME (Type) <i>E. C. H. Schmidt</i>		22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>3/24/58</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Bozman Cemetery</i>	22d. LOCATION (City, town, or county) <i>Bozman</i>	(State) <i>2nd</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Hamilton Harrison, St. Michaels.</i>		ADDRESS <i>St. Michaels.</i>		24a. REC'D BY REGISTRAR <i>MAR 28 1958</i>		24b. REGISTRAR'S SIGNATURE <i>At. 11:00 a.m.</i>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## CERTIFICATE OF DEATH

REG. NO.

NAME  
HOBBSDECEASED PERSON  
ELLEN H. HOBBS  
Died 20 January 1968

X

FEDERAL BUREAU OF INVESTIGATION - CLEVELAND

RECEIVED  
FEDERAL BUREAU OF INVESTIGATION  
FEB 21 1968  
8661 CO 1000FEDERAL BUREAU OF INVESTIGATION  
Cleveland Office  
FEB 21 1968  
E.G.H. 4-11-68

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03773

FOR STATE  
HEALTH DEPT.

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.  
**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-tranit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1		3785										Reg. Dist. No.	
1. PLACE OF DEATH a. COUNTY		TALBOT				MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		EASTON				c. LENGTH OF STAY IN lb DOA				d. STATE MARYLAND b. COUNTY TALBOT			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		MEMORIAL HOSPITAL				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				40 EASTON			
3. NAME OF DECEASED (Type or print)		First Curtis Lee				Middle Hines		d. STREET ADDRESS 5 Graham St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday) yrs.		10. IF UNDER 1 YEAR Months <input type="checkbox"/> 7 Days <input type="checkbox"/>		11. IF UNDER 24 HRS. Hours <input type="checkbox"/> 19 Min. <input type="checkbox"/>	
male		colored		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Aug. 10, 1957		12. CITIZEN OF WHAT COUNTRY?					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		Md		12. CITIZEN OF WHAT COUNTRY?					
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME											
Silas Dawson		Shirley Jean Hines											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address							
				H. D. Records									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								INTERVAL BETWEEN ONSET AND DEATH					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Advanced acute purulent meningitis											
340.3		DUE TO Empyema-right											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b) Axillary abscess-right											
DUE TO		(c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a. m. <input type="checkbox"/> p. m. <input type="checkbox"/>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) <input type="checkbox"/>		(State)					
19													
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <i>Lorenz Whetley</i>						M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 12-14-58					
EXAMINER'S NAME (Type) WELTY													
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>3/15/58</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Richards Cemetery</i>		22d. LOCATION (City, town, or county) <i>Easton, Md.</i>		(State) <i>Md.</i>					
23. FUNERAL DIRECTOR'S SIGNATURE <i>James B. Schell, Easton, Md.</i>		ADDRESS <i>2080162 XV4</i>		24a. REC'D BY REGISTRAR <i>MAR 18 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Asst. Sec. of Health</i>							
VS. A15MF BM 2/57													

BUREAU V. S.

MAR 18 1958

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3786

## CERTIFICATE OF DEATH

Reg. Dist. No.

03774

1. PLACE OF DEATH o. COUNTY <i>Talbot</i>		MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE <i>Md.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>		c. LENGTH OF STAY IN lb <i>4 days.</i>	b. COUNTY <i>Queen Anne's</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Memorial Hospital</i>		d. STREET ADDRESS <i>91 ml</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Stevensville, Md. 17x-2</i>	
3. NAME OF DECEASED (Type or print) <i>Ruth</i>		First <i>A</i>	Middle <i>Holden</i>	Last 4. DATE OF DEATH <i>March 27 1958</i>
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>December 14, 1892</i>	9. AGE (In years lost birthday) <i>65 yrs.</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>	11. BIRTHPLACE (State or foreign country) <i>Delaware</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>Aguilla Usilton</i>		14. MOTHER'S MAIDEN NAME <i>Mary Holliday</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>unknown</i>	17. INFORMANT <i>Mrs. Mary E. Dodd (daughter)</i>	Address <i>200</i>

## 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)*420.1*

DUE TO

*Myocardial infarction*INTERVAL BETWEEN  
ONSET AND DEATH  
*2 wks*Conditions, if any, which  
gave rise to immediate  
cause (a), stating the under-  
lying cause lost.  
(b)  
DUE TO  
(c)

## PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY  
PERFORMED?  
YES  NO 

## MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year  
Hour o. m.      20d. INJURY OCCURRED  
p. m.      While Nat while  
of work  of work 20e. PLACE OF INJURY (Home, farm,  
factory, street, office bldg., etc.)  
*1723*

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from *3/23*, 1958, to *3/27*, 1958, that I last saw the deceased  
alive on *3/26*, 1958, and that death occurred at *2:10 AM*, from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL  
SIGNATURE  
*Thurston Harrison**Chest Mayland 31 Mar 58*PHYSICIAN'S  
NAME (Type)*THURSTON HARRISON*

22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>3/30/58</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Stevensville</i>	22d. LOCATION (City, town, or county) <i>Stevensville Md</i>
23. FUNERAL-DIRECTOR'S SIGNATURE <i>E. L. Sam Burkhill</i>	ADDRESS <i>1000 W. 36th St. Baltimore</i>	24a. REC'D BY REGISTRAR DATE <i>APR 2 '58</i>	24b. REGISTRAR'S SIGNATURE <i>Aut. Search</i>

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## CERTIFICATE OF DEATH

DECEASED'S NAME	AGE	SEX	CAUSE OF DEATH
EDWARD J. KELLY	50	MALE	ACUTE HEART FAILURE
ADDRESS			
1015 N. 10TH ST., MILWAUKEE, WI			
MATERIAL TESTED			
BLOOD			
TESTS			
Hemoglobin: 10.0 gm.			
Hematocrit: 30.0%			
White Blood Cells: 7,500/mm <sup>3</sup>			
Red Blood Cells: 4,500,000/mm <sup>3</sup>			
Platelets: 150,000/mm <sup>3</sup>			
Urinalysis: Negative			
Blood Culture: Negative			
Postmortem Findings			
Heart: Enlarged, weight 450 gm. Heart muscle was pale and flaccid. There was no evidence of acute myocardial infarction. The coronary arteries were normal. The heart valves were normal. The lungs were edematous. The liver was enlarged, weight 1,500 gm. The kidneys were normal. The spleen was normal. The brain was normal.			
Autopsy Report			
Autopsy performed by Dr. John J. O'Farrell, M.D., at the request of the Coroner's Office. Autopsy report filed under Case No. 55-1000.			
Signature of Physician			
John J. O'Farrell, M.D.			
Date			
APR 2 1959			

BUREAU X. S.  
RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3787

## CERTIFICATE OF DEATH

Reg. Dist. No.

03775

1. PLACE OF DEATH a. COUNTY <i>Talbot</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Chestertown</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>		c. LENGTH OF STAY IN 1b <i>18 hrs</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Grasonville</i>		d. STREET ADDRESS <i>No</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Memorial Hospital</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First <i>James</i>	Middle <i>A.</i>	4. DATE OF DEATH <i>Hunter</i>	Month <i>March</i>	Day <i>23</i>	Year <i>1958</i>
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>August 15, 1888</i>	9. AGE (In years lost birthday) <i>69 yrs.</i>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY <i></i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>		
13. FATHER'S NAME <i>EZEKIEL HUNTER</i>		14. MOTHER'S MAIDEN NAME <i>ANNA STANT</i>		Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i>		16. SOCIAL SECURITY NO. <i>?</i>		17. INFORMANT <i>WILLIAM HUNTER (SON) GRASONVILLE, MD</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>421.1</i>		Cerebral arterio stenosis		INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b)		Moxine intra-intestinal hemorrhage					
DUE TO <i></i>		Colitis, type undetermined					
DUE TO <i></i>							
DUE TO <i></i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. <i>Aug. 19</i>		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>M.D. 219 S West 11th St</i>		20f. (City or town) <i>Centreville</i>	(County) (State) <i>Md.</i>
21. I certify that I attended the deceased from olive on <i>19</i> , 19 <i>58</i> , and that death occurred at <i>4:05 PM</i> , from the causes and on the date stated above.				ADDRESS (Street, city or town, state) <i>219 S West 11th St, Centreville, Md.</i>		DATE SIGNED <i>24 Mar 1958</i>	
ACTUAL SIGNATURE <i>Oliver Schmid</i>		PHYSICIAN'S NAME (Type) <i>E.C.H. Schmid</i>					
22a. BURIAL CREMATION, REMOVAL (Specify) <i>March 25, 1958</i>		22b. DATE THEREOF <i>March 25, 1958</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Chesterfield Cemetery</i>		22d. LOCATION (City, town, or county) <i>Centreville, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Edward Barton of Easton Bur. Centreville Maryland.</i>		ADDRESS <i></i>		24e. REC'D BY REGISTRAR DATE MAR 28 '58		24f. REGISTRAR'S SIGNATURE <i>Detouch</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

WYOMING STATE DEPARTMENT OF HEALTH-OUTCOMES 18

MAR 28 1958

REGELIV ED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3788

## CERTIFICATE OF DEATH

Reg. Dist. No.

03776

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
Talbot MARYLAND		b. STATE Maryland b. COUNTY Talbot	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b	
EASTON		19 da.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Memorial Hospital		X St. Michaels	
e. STREET ADDRESS		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Middle Lost 4. DATE OF DEATH	
Cecil		Keithley 3 Month 3 Day 12 Year 1958	
5. SEX		6. COLOR OR RACE	
M		W	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
WIDOWED <input checked="" type="checkbox"/>		3-8-1890	
DIVORCED <input type="checkbox"/>		9. AGE (In years last birthday) 68 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
NONE		NONE	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Maryland		USA	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
John Keithley		Rebecca L. FARBANK	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
unknown		17. INFORMANT	
(If yes, give war or dates of service)		Address	
unknown		Marcelline L. Jacobs (wife) 1500 Burnie Avenue	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		of 2 days	
420.1			
DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)			
DUE TO			
Chronic Arterial Disease		2 years	
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED?	
Chronic Pulmonary Fibrosis & Emphysema		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3/1/58 to 3/12/58, that I last saw the deceased alive on 3/12/58, and that death occurred at 8:50 AM, from the causes and on the date stated above.		ADDRESS (Street, city or town, state)	
ACTUAL SIGNATURE R. Lane Wroth		DATE SIGNED 3-12-58	
PHYSICIAN'S NAME (Type) R. LANE WROTH		ST. MICHAELS, MARYLAND	
22a. BURIAL, CREMATION, REMOVAL (Specify) Nec 15-1958		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORIALy		22d. LOCATION (City, town, county) St. Michaels Md	
23. FUNERAL DIRECTOR'S SIGNATURE J. Hambleton Garrison, St. Michaels		ADDRESS	
24a. REC'D BY REGISTRAR MAR 17 '58		24b. REGISTRAR'S SIGNATURE Alice Smith	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU Y. S.  
MAR 17 1953  
PREGELIA E.O.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 5 Film G227 3-28-58 et  
3871 CERTIFICATE OF DEATH

03777

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Selby</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Ocean County</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>St Michaels</i>		c. LENGTH OF STAY IN 1b <i>3 months</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Centreville</i>		d. STREET ADDRESS <i>Commerce St -</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Riviera Nursing Home</i>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <i>PERRY</i>		First	Middle	Lost	4. DATE OF DEATH <i>Kontos</i>	Month	Day	Year
5. SEX (Female) <i>Femin</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH <i>October 5-1887</i>	9. AGE (In years lost birthday) <i>70 yrs.</i>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <i>Turrier</i>		11. BIRTHPLACE (State or foreign country) <i>Greece</i>		12. CITIZEN OF WHAT COUNTRY? <i>Naturalized USA</i>		
13. FATHER'S NAME <i>George Kontos</i>		14. MOTHER'S MAIDEN NAME <i>Katharine Georgakopoulos</i>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>214-09-9368</i>		17. INFORMANT <i>Tony Kontos</i>		Address <i>Centreville Maryland</i>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>33IX</i>		DUE TO <i>Cerebral Vascular Accident</i> INTERVAL BETWEEN ONSET AND DEATH <i>6 hours</i>						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO <i>Cerebral Arteriosclerosis</i>		DUE TO <i>Generalized Arteriosclerosis</i> 2 yr						
(c) DUE TO <i>Generalized Arteriosclerosis</i>		10 yr						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <i>12-26</i> , 19 <i>57</i> , to <i>3-12</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>3-7-58</i> , 19 <i>58</i> , and that death occurred at <i>7:30 P.M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>Lane White</i>		ADDRESS (Street, city or town, state) <i>Brycego St Michaels, Md</i> DATE SIGNED <i>3-15-58</i>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>March 11-58</i>		22c. NAME OF CEMETERY OR GRESMATORIUM <i>Chesapeake</i>		22d. LOCATION (City, town, or county) (State) <i>Centreville Maryland</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Edward Burton, Burton Bros Centreville Maryland</i>		ADDRESS		24a. REC'D BY REGISTRAR DATE <i>Mar 20 '58</i>		24b. REGISTRAR'S SIGNATURE <i>John E. Smith</i>		

WISCONSIN STATE LIBRARY - MADISON - WISCONSIN

CERTIFICATE OF DEATH

1958

RECEIVED

BUREAU X

MAR 20 1958

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3789

## **CERTIFICATE OF DEATH**

**Reg. Dist. No.**

.03778

1. PLACE OF DEATH a. COUNTY <b>TALBOT</b>			MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MARYLAND</b>			b. COUNTY <b>ZILEEN ANNE</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>STEVENSVILLE EASTON, MD</b>			c. LENGTH OF STAY IN lb <b>5 days</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>STEVENS VILLE, MD.</b>			d. STREET ADDRESS <b>None</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL OF EASTON, MD</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>GEORGE</b>			First	Middle	Lost	4. DATE OF DEATH <b>LANG</b>	Month	Doy	Year	<b>MARCH 2 1958</b>	
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>APRIL 5, 1890</b>	9. AGE (In years lost, birthday) yrs. <b>69</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PARK POLICEMAN</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Not given</b>			11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>		
13. FATHER'S NAME <b>Mr JOHN LANG</b>			14. MOTHER'S MAIDEN NAME <b>MARY KLUTCH</b>								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16. SOCIAL SECURITY NO. <b>NONE</b>			17. INFORMANT <b>Mr GEORGE LANG</b>			Address <b>2523 HILLCREST AVE BALTO 14 MD</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) <b>241X</b>			DUE TO <b>Brucellosis pneumonia</b>						INTERVAL BETWEEN ONSET AND DEATH <b>days</b>		
Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause lost. (b) <b>491X</b>			DUE TO <b>Bronchial aspergillosis</b>						?		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) <b>491X</b>									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>25 Feb 1958</b>								
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>None</b>			20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <b>25 Feb 1958</b> , to <b>12 Mar 1958</b> , that I last saw the deceased alive on <b>2 Mar 1958</b> , and that death occurred at <b>10 AM</b> , from the causes and on the date stated above.						ADDRESS (Street, city or town, state) <b>Baltimore, Md</b>			DATE SIGNED <b>25 Mar 1958</b>		
ACTUAL SIGNATURE <b>Thurston Harrison</b>			M.D.								
PHYSICIAN'S NAME (Type) <b>THURSTON HARRISON</b>											
22a. BURIAL/CREMATION REMOVAL (Specify) <b>B</b>			22b. DATE THEREOF <b>5/5/58</b>			22c. NAME OF CEMETERY OR CREMATORIUM <b>Roxbury Cemetery</b>			22d. LOCATION (City, town, or county) <b>Baltimore, Md</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. Thompson, Esq., Esq., Esq.</b>			ADDRESS <b>1700 E. Pratt St., Baltimore, Md.</b>			24a. REC'D BY REGISTRAR <b>REC'D 0 150</b>			24b. REGISTRAR'S SIGNATURE <b>DeLoach</b>		

**O HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**O FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit Permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAR 10 1958

**RECEIVED**

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03779

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 5 may be retained by your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Talbot</u>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u>		b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. LENGTH OF STAY IN lb <u>4 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		d. STREET ADDRESS <u>Dover Road</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Easton Memorial Hospital</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Florence</u>		First	Middle	Last	4. DATE OF DEATH Month <u>March</u> Day <u>13</u> Year <u>1958</u>	Month	Day
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-16-1882</u>	9. AGE (In years last birthday) <u>75</u> yrs.	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Alfred Benson</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Thomas</u>		Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>916.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>House burned down</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>4 hr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Burned trying to put out fire in home</u>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>3-9</u> p. m. <u>1958</u>		20d. INJURY OCCURRED White or work <input type="checkbox"/> Not white or work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>home</u>		20f. (City or town) <u>Easton Tal</u>	(County) <u>Ind</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>						DATE SIGNED <u>3-13-58</u>	
ACTUAL SIGNATURE <u>Lori Shultz</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) <u>WELTY</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Funeral</u>		22b. DATE THEREOF <u>3/15/58</u>		22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <u>New Town, Conn.</u>		22d. LOCATION (City, town, or county) <u>Cordova Rd, Ind.</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James H. Shultz</u>				24a. REC'D BY REGISTRAR <u>MAR 18 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Alt. Search</u>	
VS. A15ME SM 2/57							

MISSOURI STATE DEPARTMENT OF REVUE - BUREAU OF INVESTIGATION  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V.

MAR 18 1958

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3791

## CERTIFICATE OF DEATH

03780

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Talbot</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Caroline</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>		c. LENGTH OF STAY IN lb <i>16 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Denton</i>		d. STREET ADDRESS <i>West Jensen</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Memorial Hospital</i>				d. STREET ADDRESS <i>West Jensen</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Mary</i>		First	Middle	Lost	4. DATE OF DEATH <i>March 10 1958</i>	Month	Day	Year	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>April 21, 1883</i>	9. AGE (In years last birthday) <i>74 yrs.</i>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House-wife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>N/A</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
13. FATHER'S NAME <i>William Reed</i>				14. MOTHER'S MAIDEN NAME <i>Emily Warren</i>		Address <i>911 Lewis C. Mitchell</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>99-11-742</i>		17. INFORMANT <i>M. Lewis C. Mitchell</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.0</i> DUE TO <i>arteriosclerotic heart disease</i> INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Easton Md.</i>		20f. (City or town) <i>Easton</i>		(County) <i>Md.</i>	(State) <i>Md.</i>
21. I certify that I attended the deceased from <i>April 10, 1958</i> , to <i>3/10 1958</i> , that I last saw the deceased alive on <i>3/10 1958</i> , and that death occurred at <i>7:55 PM</i> , from the causes and on the date stated above.				ADDRESS (Street, city or town, state) <i>Easton Md.</i>		DATE SIGNED <i>3/10/58</i>			
ACTUAL SIGNATURE <i>H. J. Reed</i>		M.D.							
PHYSICIAN'S NAME (Type) <i>P. E. C. W.</i>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>3/14/58</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Mt. Olive</i>		22d. LOCATION (City, town, or county) <i>Goldsboro, Md.</i>		(State) <i>Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. G. Boulaiais</i>		ADDRESS <i>Greensboro, Md.</i>		24a. REC'D BY REGISTRAR DATE MAR 14 '58		24b. REGISTRAR'S SIGNATURE <i>Albertsuch</i>			

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3792

## CERTIFICATE OF DEATH

Reg. Dist. No. 03781

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Talbot</u>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u>		b. COUNTY <u>Queen Anne</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. LENGTH OF STAY IN lb <u>3 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Centreville</u>		d. STREET ADDRESS <u>No 1</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Easton Memorial Hospital</u>				d. STREET ADDRESS <u>No 1</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Romie H Payne</u>		First	Middle	Lost	4. DATE OF DEATH Month <u>March</u> Day <u>13</u> Year <u>1958</u>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
5. SEX <u>Male</u> 6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-25-1895</u>		9. AGE (In years last birthday) <u>62 yrs.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Merchant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Store (Grocery)</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Bowers</u>		14. MOTHER'S MAIDEN NAME <u>Julia Hollingsworth</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no <input type="checkbox"/> <u>No</u> ) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>No 1</u>		17. INFORMANT <u>Mrs Clara Payne</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory</u>		DUE TO <u>Renal Cell Carcinoma</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
		Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u>		DUE TO <u> </u>		T	
		(c) <u> </u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u> </u>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u>Easton</u> (County) <u>Md.</u> (State) <u>Md.</u>	
21. I certify that I attended the deceased from <u>May 13, 1958</u> , to <u>3/13/58</u> , that I last saw the deceased alive on <u>3/12/58</u> , 19 <u>58</u> , and that death occurred at <u>Easton Md.</u> from the causes and on the date stated above.				ADDRESS (Street, city or town, state) <u>Church Hill</u>		DATE SIGNED <u>3/13/58</u>	
ACTUAL SIGNATURE <u>J. H. Cop</u>		PHYSICIAN'S NAME (Type) <u>P E Cox</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/13/58</u>		22c. NAME OF CEMETERY OR CREMATORIUM <u>Church Hill</u>		22d. LOCATION (City, town, or county) <u>Queen Anne</u> (State) <u>Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>E. L. Lane</u>		ADDRESS <u>Church Hill Md.</u>		24a. REC'D BY REGISTRAR <u> </u>		24b. REGISTRAR'S SIGNATURE <u>Aut. Exch</u>	

BUREAU V.C.  
MAR 17 1958  
PREGELAEC

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3802

## CERTIFICATE OF DEATH

Reg. Dist. No.

03782

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>TALBOT</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ST. MICHAELS</u>		c. LENGTH OF STAY IN 1b <u>5 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ST. MICHAELS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION —		d. STREET ADDRESS —		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>John</u>		First <u>D.</u>	Middle <u>Powers</u>	Last	4. DATE OF DEATH Month <u>MARCH</u> Day <u>22</u> Year <u>1958</u>
S. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>MARCH 14, 1877</u>	9. AGE (In years lost birthday) <u>81</u> yrs.	IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FOREMAN MACHINIST</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>METALS</u>	11. BIRTHPLACE (State or foreign country) <u>IRELAND</u>	12. CITIZEN OF WHAT COUNTRY? <u>U. IRELAND</u>	
13. FATHER'S NAME <u>John Powers</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —		16. SOCIAL SECURITY NO. —	17. INFORMANT <u>John A. Powers, ST. MICHAELS MD.</u>	Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiac failure</u> 422.1 DUE TO <u>arteriosclerotic cardio</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>vascular</u> — (c) <u>—</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>	
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <u>Valhalla Winchester S. W.</u>	(County) <u>St. Michaels</u>	(State) <u>MD.</u>
21. I certify that I attended the deceased from <u>3-22</u> , 19 <u>58</u> , to <u>3-22</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>3-22</u> , 19 <u>58</u> , and that death occurred at <u>2 AM</u> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>Guy M. Reeser</u>	PHYSICIAN'S NAME (Type) <u>Guy M. Reeser</u>	ADDRESS (Street, city or town, state) <u>St. Michaels Md</u>			DATE SIGNED <u>3-23-58</u>
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>3-25-58</u>	22b. DATE THEREOF <u>3-25-58</u>	22c. NAME OF CEMETERY OR CREMATORIAL <u>Gate of Heaven</u>	22d. LOCATION (City, town, or county) <u>Valhalla Winchester S. W.</u>	(State) <u>MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>G. Stanfeler Harrison</u>		ADDRESS <u>St. Michaels</u>	24a. REC'D BY REGISTRAR <u>Reeser</u>	24b. REGISTRAR'S SIGNATURE <u>Reeser</u>	
VS A15 (4) 1SM 9/55		DATE <u>MAR 27 '58</u>			

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18  
CERTIFICATE OF DEATH

BUREAU V.

MAR 27 1953

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03783

## CERTIFICATE OF DEATH

Reg. Dist. No.

3873

1. PLACE OF DEATH a. COUNTY <b>Talbot</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Easton - Rural</b>		c. LENGTH OF STAY IN lb <b>20 yrs</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Easton, Rural</b>	
		d. STREET ADDRESS	
		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print)	First <b>Clara</b>	Middle <b>Isabel</b>	Last <b>Schofield</b>	4. DATE OF DEATH <b>Mar. 13 1958</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>Jan 25, 1868</b>	9. AGE (In years last birthday) <b>90 yrs.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>	11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Frank H. Schofield</b>		14. MOTHER'S MAIDEN NAME <b>Mary Rodgers</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT <b>Perry Schofield</b>	Address <b>1098 81st St New York-28</b>

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) <b>Myocardial Infarction</b> DUE TO <b>arteriosclerotic coronary disease</b> ? (c)		<b>Sudden</b>

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that I attended the deceased from **July 1957** to **March 1958** that I last saw the deceased alive on **Dec 1, 1957**, and that death occurred at **11:45 M.** from the causes and on the date stated above.

ACTUAL SIGNATURE <b>P. E. Cox</b>	M.D.	ADDRESS (Street, city or town, state) <b>Easton, Md.</b>	DATE SIGNED
PHYSICIAN'S NAME (Type) <b>P. E. Cox</b>			

22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>3/17/58</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Arlington National Cemetery</b>	22d. LOCATION (City, town, or county) <b>Arlington</b> ( <b>State</b> ) <b>Virginia</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John D. Wilkins</b>	ADDRESS <b>Easton, Md.</b>	24a. REC'D BY REGISTRAR DATE <b>MAR 17 '58</b>	24b. REGISTRAR'S SIGNATURE <b>Alfred Finch</b>

MARYLAND STATE DEPARTMENT OF HIGHWAYS - BALTIMORE 18

CERTIFICATE OF DATA

BUREAU Y. S.

MAR 17 1958

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3793

## CERTIFICATE OF DEATH

Reg. Dist. No.

03784

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) b. STATE				
Talbot MARYLAND		Maryland Caroline				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b 24 hrs.				
Easton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS J. Main St.				
Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First Lee	Middle Albert			
		Last Smith	4. DATE OF DEATH Month 3 Day 23 Year 1958			
5. SEX  M		6. COLOR OR RACE  W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
		8. DATE OF BIRTH June 3, 1904				
9. AGE (in years last birthday) 53 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		10b. KIND OF BUSINESS OR INDUSTRY Unknown	11. BIRTHPLACE (State or foreign country) Maryland			
12. CITIZEN OF WHAT COUNTRY? USA						
13. FATHER'S NAME George Smith		14. MOTHER'S MAIDEN NAME Ida Dukes				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO.	17. INFORMANT MRS. Blanche Smith (wife) <i>deceased</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Brucellosis pneumonia (c) Gold Toxicity		INTERVAL BETWEEN ONSET AND DEATH 2 days 1 week days				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Smyrna	(County)	(State)
21. I certify that I attended the deceased from Sept. 1, 1957, to 31/23, 1958, that I last saw the deceased alive on 31/23, 1958, and that death occurred at 9:25 AM, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) M.D. 11 Hanover St. Easton, Md.		DATE SIGNED		
ACTUAL SIGNATURE  Shepard Krech Jr.		PHYSICIAN'S NAME (Type) Shepard Krech Jr.				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept 26 58	22c. NAME OF CEMETERY OR CREMATORIUM St. Eliz. Cemetery	22d. LOCATION (City, town, or county) Federalburg Md.		
23. FUNERAL DIRECTOR'S SIGNATURE  Harvey Wilson - Federalburg, Md.		ADDRESS		24e. REC'D BY REGISTRAR MAR 28 '58	24f. REGISTRAR'S SIGNATURE DeLoach	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## WISCONSIN STATE DEPARTMENT OF HEALTH - BIRTHING

## CERTIFICATE OF DEATH

NAME OF DECEASED	SEX	AGE	DEATH DATE
EDWARD J. KELLY	MALE	40	MAR 28 1958
ADDRESS			
1015 N. 10TH ST.			
MILWAUKEE, WISCONSIN			
NAME AND ADDRESS OF HOSPITAL			
HOSPITAL OF THE GOOD SHEPHERD			
MILWAUKEE, WISCONSIN			
NAME AND ADDRESS OF DOCTOR			
DR. RICHARD L. HARRIS			
MILWAUKEE, WISCONSIN			
NAME AND ADDRESS OF FUNERAL DIRECTOR			
J. E. COOPER			
MILWAUKEE, WISCONSIN			
NAME AND ADDRESS OF PERSON FILING CERTIFICATE			
BUREAU V. S.			
MILWAUKEE, WISCONSIN			
NAME AND ADDRESS OF PERSON RECEIVING CERTIFICATE			
RECEIVED			
MAR 28 1958			

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3791

## CERTIFICATE OF DEATH

Reg. Dist. No.

03785

1. PLACE OF DEATH a. COUNTY <i>Talbot</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MARYLAND</i> b. COUNTY <i>Talbot</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>		c. LENGTH OF STAY IN lb <i>40</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Easton Memorial Hospital</i>		d. STREET ADDRESS <i>611 Talbotton</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>William</i>	Middle <i>James</i>	Last <i>Smith</i>
4. DATE OF DEATH	Month <i>Mar</i>	Day <i>3</i>	Year <i>1958</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 14 1899</i>
9. AGE (In years last birthday) <i>58 yrs.</i>	10. IF UNDER 1 YEAR Months <i>7</i>	11. IF UNDER 24 HRS. Days <i>19</i>	12. Hours <i>10</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Pub Construction</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Highways</i>	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>James Andrew Smith</i>	14. MOTHER'S MAREN NAME <i>Kates Hendrie</i>	Address <i>611 Talbotton St Easton Md</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>214-32-3383</i>	17. INFORMANT <i>Mrs Tom J Smith, Easton Md</i>	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary of Lung, right</i>
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <i>(b) (c)</i>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour a. m. <i>19</i> p. m. <i></i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>M.D. 219 S Washington St</i>	20f. (City or town) (County) <i>Easton</i> <i>St. Marys Co.</i> (State) <i>Md.</i>
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at _____, 19_____, M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>219 S Washington St</i> <i>3 March 58</i>			
ACTUAL SIGNATURE <i>E.C.H. Schmid</i>	DATE SIGNED <i>3 March 58</i>		
PHYSICIAN'S NAME (Type) <i>E.C.H. Schmid</i>	M.D. <i>Easton 16, Maryland</i>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Mch 5 1958</i>	22b. DATE THEREOF <i>Mch 5 1958</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Wesley Chapel</i>	22d. LOCATION (City, town, or county) (State) <i>Bethel</i> <i>Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>R. Mulcahy</i>	ADDRESS <i>Easton Md</i>	24a. REC'D BY REGISTRAR DATE <i>Mar 10 1958</i>	24b. REGISTRAR'S SIGNATURE <i>Webb</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit Permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. S.

MAR 10 1958

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3804

## CERTIFICATE OF DEATH

Reg. Dist. No.

03786

1. PLACE OF DEATH o. COUNTY <b>Talbot</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Talbot</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>rural-Easton</b>		c. LENGTH OF STAY IN lb <b>54 yrs</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>rural-Easton</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Matthewstown Road</b>				d. STREET ADDRESS <b>Matthewstown Road</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>James Elmer</b>	Middle <b></b>	Last <b>Swann</b>	4. DATE OF DEATH <b>March 22 1958</b>	Month <b>March</b>	Doy <b>22</b>	Year <b>1958</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>Sept. 30, 1884</b>	9. AGE (In years less birthday) <b>73</b> yrs.	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. DAYS <b>0</b>	Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer-ret.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Isaac Swann</b>		14. MOTHER'S MAIDEN NAME <b>May Harrison</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Mrs. Minnie T. Swann, Easton, RD, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <b>Arteriosclerotic heart disease.</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 1958, to _____, 1958, that I last saw the deceased alive on _____, 1958, and that death occurred at _____, 1958, M., from the causes and on the date stated above. ACTUAL SIGNATURE <b>B. Cop</b> PHYSICIAN'S NAME (Type)						ADDRESS (Street, city or town, state) <b>Easton, Md.</b> DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/24/57</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Spring Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Easton, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>R. J. Gaynor</b>		ADDRESS <b>Easton, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>MAR 31 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Alv. Beuch</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## CERTIFICATE OF DEATH

NAME OF DECEASED		NAME OF DOCTOR	
JAMES LEE HARRIS		JOHN W. COOPER	
ADDRESS		ADDRESS	
1111 E. 36TH ST.		1111 E. 36TH ST.	
BALTIMORE, MD 21212		BALTIMORE, MD 21212	
AGE		AGE	
65		65	
SEX		SEX	
MALE		MALE	
MATERIAL TESTED		TESTS	
BLOOD		BLOOD	
CAUSE OF DEATH		DEATH CERTIFIED	
HEART DISEASE		DOCTOR'S SIGNATURE	
		JOHN W. COOPER	
		MD	
		MAY 1, 1988	
		RECEIVED	
		MAR 31 1988	

BUREAU V. S.

MAR 31 1988

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3795

## CERTIFICATE OF DEATH

Reg. Dist. No.

13787

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death: Pages 4 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Queen Anne</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Foxton</i>		c. LENGTH OF STAY IN 1b <i>40 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Chester town</i>		d. STREET ADDRESS <i>None</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>MEMORIAL HOSPITAL</i>				d. STREET ADDRESS <i>None</i>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>James</i>		First	Middle <i>Lofton</i>	Last <i>Teat</i>	4. DATE OF DEATH Month <i>March</i>	Day <i>25</i>	Year <i>1958</i>
5. SEX <i>M</i>	6. COLOR OR RACE <i>Wh.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>12/27/1893</i>	9. AGE (Years Months Days) <i>64 yrs</i>	IF UNDER 1 YEAR Months <i>0</i>	IF UNDER 24 HRS. Hours <i>0</i>	Min. <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Brakeman</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Rail road.</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Adolphus Teat</i>		14. MOTHER'S MAIDEN NAME <i>Catherine V. Lynch</i>		Address <i>Chestertown Md.</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>Unknown</i>		17. INFORMANT <i>Mrs. W.R. Kaufman (daughter)</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i> DUE TO Coronary occlusion	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <i>2 weeks</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Cholelithiasis.</i>		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at <i>6:28 P.M.</i> from the causes and on the date stated above.		ACTUAL SIGNATURE <i>E.C.H. Schmidt</i>		M.D. <i>219 S Washington St 26 Nov 58</i>		ADDRESS (Street, city or town, state) <i>Easton 16, Maryland</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>3/29/58</i>		22b. DATE THEREOF <i>3/29/58</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Fairwood Cemetery</i>		22d. LOCATION (City, town, or county) <i>Baltimore, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. Willis Wells</i>		ADDRESS <i>Chestertown Md.</i>		24a. REC'D BY REGISTRAR DATE <i>MAR 28 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Asst. coach</i>	

## CERTIFICATE OF DEATH

MARCH 28, 1958

MADE TO JOHN D. COOK

DEATH CERTIFICATE

NAME OF DECEASED: JOHN D. COOK

ADDRESS OF DECEASED: 100 MARCH ISLANDS STATE GOVERNMENT

DATE OF DEATH: MARCH 28, 1958

CAUSE OF DEATH: SUICIDE

TIME OF DEATH: 10:00 A.M.

METHOD OF DEATH: BY GUNSHOT

TESTIMONY: JOHN D. COOK

BUREAU V. S.

MAR 28 1958

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03788

## CERTIFICATE OF DEATH

Reg. Dist. No.

3796

1. PLACE OF DEATH a. COUNTY <i>Talbot</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>	c. LENGTH OF STAY IN 1b <i>8 days</i>	b. COUNTY <i>Talbot</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Sherwood</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Memorial Hospital</i>	e. STREET ADDRESS <i>11mle</i>	d. STREET ADDRESS <i>11mle</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <i>Ella R</i>	First <i>Ella</i>	Middle <i>R</i>	Last <i>watson</i>		
4. DATE OF DEATH <i>March 8 1958</i>	Month <i>March</i>	Day <i>8</i>	Year <i>1958</i>		
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>October 8 1884</i>		
9. AGE (In years lost birthday) <i>73 yrs.</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>	11. KIND OF BUSINESS OR INDUSTRY <i>None</i>	12. BIRTHPLACE (State or foreign country) <i>Maryland</i>		
13. CITIZEN OF WHAT COUNTRY? <i>USA</i>	14. FATHER'S NAME <i>John Roberts</i>	15. MOTHER'S MAIDEN NAME <i>Unknown</i>			
16. SOCIAL SECURITY NO. <i>Unknown</i>	17. INFORMANT <i>Milton Watson - husband - Sherwood</i>	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>cerebral hemorrhage</i> DUE TO <i>arteriosclerotic cerebral -</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) <i>vascular.</i>	INTERVAL BETWEEN ONSET AND DEATH <i>8 days</i>		
19. MEDICAL CERTIFICATION ACTUAL SIGNATURE <i>Hugh Dicker</i>	20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Hyperlipidemic condition</i>	21. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>No</i>	20f. (City or town) <i>Baltimore</i>	(County) <i>Md</i>	(State) <i>Md</i>
21. I certify that I attended the deceased from <i>April 1952</i> to <i>3-8 1958</i> , that I last saw the deceased alive on <i>3-8 1958</i> , and that death occurred at <i>9:15 PM</i> , from the causes and on the date stated above.	ADDRESS (Street, city or town, state) <i>No 11mle St Michaels Md</i>	DATE SIGNED <i>3-10-58</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>3/11/58</i>	22b. DATE THEREOF <i>3/11/58</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Loudon Park Cemetery</i>	22d. LOCATION (City, town or county) <i>Balto. Md.</i>	(State) <i>Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Wm J. Tichner &amp; Sons North &amp; La. Ave.</i>	ADDRESS <i>Wm J. Tichner &amp; Sons North &amp; La. Ave.</i>	24a. REC'D BY REGISTRAR <i>Mar 12 '58</i>	24b. REGISTRAR'S SIGNATURE <i>Autograph</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

EF DOCUMENTS-172000 TO 180000 STATE OF ILLINOIS

BUREAU A 7

MAR 12 1959

REGELIV ED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3797

## CERTIFICATE OF DEATH

Reg. Dist. No 13789

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH o. COUNTY <u>Talbot</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE <u>MARYLAND</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. LENGTH OF STAY IN 1b <u>24 hrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Easton Memorial Hosp.</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oxford</u>	
3. NAME OF DECEASED (Type or print) <u>ELbert</u>		d. STREET ADDRESS	
First <u>EL</u>		Middle <u>bert</u>	Last <u>Wilson</u>
4. DATE OF DEATH Month <u>3</u>		Day <u>1</u>	Year <u>1958</u>
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Col.</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 1895</u>	
WIDOWED <input type="checkbox"/>		9. AGE (In years last birthday) <u>64 yrs.</u>	
DIVORCED <input type="checkbox"/>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>waterman</u>	
11. KIND OF BUSINESS OR INDUSTRY <u>oystering</u>		12. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Robert Wilson</u>		14. MOTHER'S MAIDEN NAME <u>Mary Bentley</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? <u>yes</u>		16. SOCIAL SECURITY NO. <u>World War I</u>	
17. INFORMANT <u>Nellie Wilson (wife) Oxford, Md</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>204.4</u>		DUE TO <u>Pneumonia</u>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Leukemia</u>		DUE TO <u>Leukemia</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>493 X</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u>Bethel</u>	
(County) <u>Wicomico Co.</u>		(State) <u>Md.</u>	
21. I certify that I attended the deceased from <u>Nov. 1957</u> , to <u>March 1958</u> , that I last saw the deceased alive on <u>March 1, 1958</u> , and that death occurred at <u>2:25 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Donald F. Bartley M.D.</u>		ADDRESS (Street, city or town, state) <u>9 N. HANSON ST.</u>	
PHYSICIAN'S NAME (Type) <u>DONALD F. BARTLEY MD</u>		DATE SIGNED <u>3-1-58</u>	
22a. BURIAL/CREMATION REMOVAL (Specify) <u>3/5/58</u>		22b. DATE THEREOF <u>3/5/58</u>	
22c. NAME OF CEMETERY OR CREMATORIAL <u>Oxford Cemetery</u>		22d. LOCATION (City, town, or county) <u>Oxford, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James R. Dahl Easton, Md.</u>		24a. REC'D BY REGISTRAR <u>MARY 58</u>	
ADDRESS <u>James R. Dahl Easton, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Allie L. French</u>	

WYOMING STATE CAPITAL OF MEDICINE

MAR 7 1953

**RECEIVED**